CULTURAL AND LINGUISTIC SUBSCRIBER NEEDS ASSESSMENT
HEALTHY FAMILIES PROGRAM
2011 – 2012 BENEFIT YEAR

California Managed Risk Medical Insurance Board
Benefits and Quality Monitoring Division

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Healthy Families Program

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Executive Summary

Introduction

Since 1998, the Managed Risk Medical Insurance Board (MRMIB) has administered California's Children's Health Insurance Program–Healthy Families Program (HFP). HFP has provided health, dental and vision coverage to more than 850,000 eligible children under the age of 19 during the 2011-12 benefit year. HFP plans are required to submit a comprehensive assessment of subscribers every five years, called the Group Needs Assessment (GNA). The GNA report follows a specified format and plans must describe methods and data used to assess the HFP population. Plans must indicate the activities to address the identified needs, gaps in services or other issues raised by the GNA. The most recent GNA was submitted in September of 2011. In September of 2012, plans submitted an update to the GNA that used the same format, compared previous and current GNA activities and provided a timeline for conducting these activities. Although all health, dental and vision plans submitted GNA reports, this report only summarizes information submitted by health plans. MRMIB will include key findings from the HFP dental plans' GNA in the 2012 Dental Quality Report.

California has long been known as a state of great diversity and this is evident in the cultural and ethnic backgrounds of the subscribers in HFP. In December 2012, nearly half or 46.7 percent of HFP subscribers were Latino. Asian/Pacific Islanders comprised 9.4 percent. Caucasians represented 9.3 percent and African Americans represented 1.8 percent. Families enrolling in HFP also have the option of providing MRMIB with their preferred primary language. In 2012, families identified 29 different languages. Because of this diversity, it is crucial that plans serving HFP provide language assistance services and culturally competent care to subscribers. MRMIB also uses this demographic information in numerous quality assessment and utilization measurement reports to assess plan performance.

The purpose of the GNA is to evaluate characteristics of HFP subscribers and identify disparities in order to develop strategies and implement programs to increase the provision of culturally and linguistically appropriate services. The GNA report, along with other required reports, assists MRMIB in monitoring plan contract requirements to ensure the cultural and linguistic needs of HFP subscribers are met.

Background

HFP health plans are required to conduct a GNA to identify the needs of subscribers as it relates to the availability of health education and cultural and linguistic programs and resources and to identify gaps in these services. The GNA specifically address the unique needs of subscribers with special health care needs, Limited English Proficient (LEP) subscribers and subscribers from diverse cultural and ethnic backgrounds.

The GNA submitted by health plans includes information in the following areas:

- Demographics and health status of HFP subscribers.
- Plan resources, including subscriber education classes and community services.
- Services provided to subscribers with special health care needs, including California Children's Services (CCS) and mental health.
- Cultural and language needs, including assistance in understanding health information.
- Analysis of the Healthcare Effectiveness and Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports by demographic variables to identify health disparities.
- Disease incidence and prevalence by ethnic group, including the most frequently diagnosed conditions by ethnicity.
- Description of the most frequently diagnosed conditions and programs to reduce disparities.

To develop this report, MRMIB reviewed the last comprehensive GNA submitted by health, dental and vision plans in 2011 along with the plan updates received in 2012. The four most frequently cited conditions in the plan reports were:

- Diabetes.
- Asthma/Upper Respiratory Infection.
- Obesity.
- Mental Health/Substance Abuse.

This report summarizes information submitted by plans about these four conditions and highlights some of the activities and programs that plans developed and implemented to address them. As a part of the GNA process, plans were also required to conduct a subscriber survey to inform their analysis. MRMIB requested that plans provide the results of their surveys and tabulated that data to measure how well the linguistic needs of subscribers were being met. The summary of responses to survey questions attempts to identify issues HFP subscribers may have had with language barriers in communicating with their doctors or attaining interpreting services. Those results are also included in this report.

In addition to the GNA, all plans participating in HFP are required to report annually on the services they provided to meet the cultural and linguistic needs of their subscribers. Previously, MRMIB reported that information in a separate report. However, MRMIB found that this information did not change significantly from year-to-year, and is also included in this report.

Key Findings

GNA information submitted by the health plans revealed several key findings. These findings include:

- For submitted data, the Hispanic population was most frequently identified as the ethnic group with the highest disparity. This gap is expected as historically Hispanics have comprised nearly 50 percent of the HFP enrollment.

- All plans provided data on disease prevalence; however some plans failed to break down the data into ethnicity categories.
- For example, Mental Health/Substance Abuse was one of the most frequently cited conditions in plan reports but only four of 17 plans provided data identifying ethnic disparities.
- In addition, some plans only reported on language and others on ethnicity. As a result, Hispanic includes both disparities reported as Hispanic or Spanish speaking.

Conclusion

MRMIB found that some plans invested significant resources in analyzing the needs of HFP subscribers and implementing programs to address them. In addition, subscriber survey results showed that a majority of subscribers either had a provider that spoke their language or did not need an interpreter. While there is room for improvement in serving the linguistic needs of subscribers, the overall replies were positive in nature.

Understanding disparities in care and identifying barriers, particularly related to language and culture, has been a long standing focus of MRMIB and its staff. For that reason, MRMIB conducts demographic analysis on most of its quality assessment reports. This analysis shows that disparities related to spoken language and ethnicity continue to exist and that it is critical not just to develop programs and strategies to address them, but to measure the results on an ongoing basis to identify those efforts that are most successful.

This report also includes highlights of some of the programs and strategies in use by HFP plans. MRMIB hopes this information will promote the sharing of best practices across plans, and may assist other state programs in the identification of successful strategies that can be adopted on a more widespread basis.

Group Needs Assessment (GNA) Report

The goal of the GNA was to improve the health outcomes of HFP subscribers by evaluating subscriber health risks; identifying their health care needs and prioritizing health education; cultural/linguistic services; and quality improvement programs and resources.

The demographic profile of HFP reflects the rich diversity that exists in California. HFP plans must address the needs of this diverse population in order to provide access to comprehensive, quality health care coverage. The ability of providers to communicate with subscribers and their parents is only one part of the equation. Participating providers and plans must also recognize that subscribers from various ethnic groups may have distinct patterns of health beliefs, values and behaviors, all of which can significantly affect the level of compliance with prescribed treatment.

Each HFP plan was required to conduct a GNA to identify the health risks, beliefs and practices of their HFP subscribers and to develop work plans in response to identified health education, cultural and linguistic needs, including a timeline for implementation. The most recent GNA and work plans were submitted in September of 2011 and updated in 2012. Highlights from the HFP dental GNA will be provided in the 2012 Dental Quality Report.

To complete the GNA, plans were required to identify the following for their HFP subscribers:

- Health needs and expectations.
- Language needs and access to language services.
- Availability and accessibility of health information and education services, along with preferred methods of learning.
- Access to technology.
- Subscriber's perception of health care experiences.
- Lifestyle choices and behaviors which influence health (e.g. tobacco use).

Plans used a variety of sources to obtain measurable data. These included subscriber demographics; disease prevalence; mental health/substance abuse data; changes in utilization of services and ethnic disparities. Plans also used their claims and utilization data and results from HEDIS and CAHPS surveys. The specific data sources are provided on page 29.

Plans used surveys, interviews and/or focus groups to obtain information directly from subscribers, network providers and community based organizations. Findings from the GNA subscriber survey are also included in this report.

The health plans reported on numerous health conditions. The four most frequently cited conditions were:

- Obesity.
- Asthma/Upper Respiratory Infection.
- Diabetes.

- Mental Health/Substance Abuse.

In addition to identifying ethnic disparities in the health conditions mentioned above, each plan identified several activities it would implement to address the information identified in the GNA.

Unfortunately, not all health plans were able to provide information regarding ethnic disparities by condition. In addition, not all plans listed current and future projects in relation to a specific health condition. Therefore, those limitations should be noted in reading this report.

Obesity

Introduction

The Data Resource Center for Child and Adolescent Health ranked California 24th in overall obesity prevalence, with 30.5 percent of the children considered overweight and obese in 2007. This is a slight improvement in rank compared to 2003, when California ranked 27th in the nation.[1] However, obesity is still growing at epidemic levels and remains an unprecedented public health crisis for children in California.[2]

Typically a child's weight must be at least 10 percent higher than what is recommended for his/her height and body type before they are considered obese. Obesity most commonly begins between the ages of 5 and 6, or during adolescence. Studies have shown that a child who is between the ages of 10 and 13 and is obese has an 80 percent chance of being an obese adult.[3]

Obesity causes are complex and include genetic, biological, behavioral and cultural factors. Medical disorders can cause obesity, but less than 1 percent of all obesity is caused by medical problems. Obesity in childhood and adolescence can be related to:

- Poor eating habits.
- Overeating or binging.
- Lack of exercise.
- Family history of obesity.
- Medical illnesses (endocrine or neurological problems).
- Medications (steroids and some psychiatric medications).
- High stress life events or changes (separations, divorce, moves, deaths or abuse).
- Family and peer problems.
- Low self-esteem.
- Depression or other emotional problems.[4]

Obesity is associated with many health risks and complications. Physical consequences include:

- Increased risk of heart disease.
- High blood pressure.
- Diabetes.
- Breathing problems.
- Trouble sleeping.[5]

There is also an increased risk of emotional problems in child and adolescent obesity. Research shows that teens with weight problems tend to have much lower self-esteem and can be less popular with their peers. Depression, anxiety and obsessive compulsive disorder can also result.[6] In addition, obesity often affects more than one family member, thereby making healthy eating and regular exercise a family activity improves the chances of successful weight control for the child or adolescent.[7]

Obesity

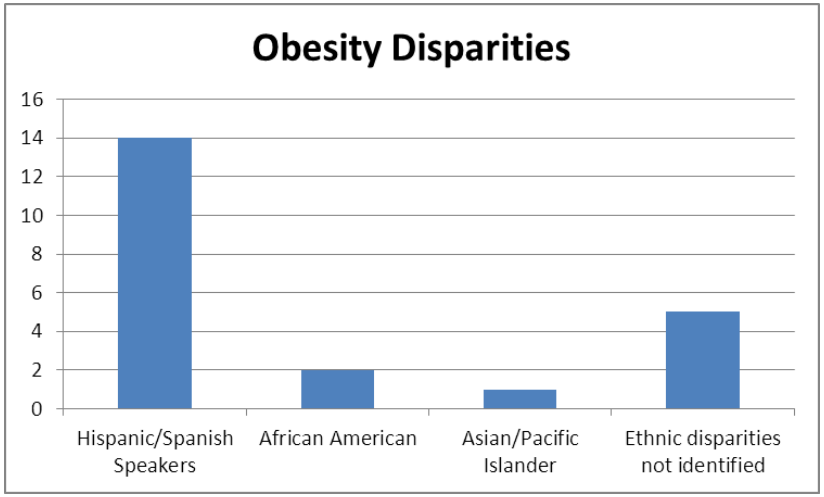
Disparities

HFP health plans reported a high obesity disparity among Hispanic subscribers. More than half of plans reported their highest obesity diagnosis rates in this group. However, an increased diagnosis rate could indicate that providers are taking a more active role to identify and refer their HFP patients for obesity prevention programs.

Chart 1 reports on the highest number of ethnicities that are affected by obesity according to data supplied by health plans:

- A total of 14 plans reported Hispanic subscribers.
- Two plans reported African American subscribers.
- One plan reported Asian/Pacific Islander subscribers.
- Five plans did not identify ethnic disparities among subscribers.

Chart 1



Key Findings

All 22 HFP health plans identified obesity as a major health problem for HFP subscribers.

Nearly all HFP health plans have implemented obesity prevention programs or made improvements to existing programs to inform families about the weight management, physical activity and nutrition.

- Most plans reported offering pediatric obesity prevention trainings to their physicians, plan staff and contracted providers. The contents of the trainings include:

- Screening, counseling and follow-up with subscribers.
- Implementation of body mass index (BMI) screening.
- Prevention and early detection of obesity risk factors.
- Brief counseling techniques.
- Accessing available plan resources and community resources.

Plan Projects

HFP health plans are contractually required to increase provider awareness of the importance of screening for overweight and obese subscribers. Health plans also are required to increase awareness of the health risks associated with being overweight and obese, as well as the importance of good nutrition and physical activity among applicants and subscribers. The plans report current and planned activities that comply with these requirements every year. Examples include:

Anthem Blue Cross EPO/HMO – Offers childhood obesity tool kits and BMI trainings to providers.

Cal-Optima – Implemented the Childhood Obesity Prevention and Treatment Program (COPTP). COPTP is a comprehensive behavior modification program addressing prevention and treatment of childhood obesity through nutrition, physical activity, portion control, healthy habits education and targeted newsletters.

Care 1st – Sends monthly class schedules of exercise, healthy eating and weight management programs.

CenCal Health – Developed Live Better Make a Change Program, which includes mailed resources, referrals and rewards for subscribers who commit to making a healthy change in nutrition and exercise.

Central California Alliance for Health – Continues to educate providers on the importance of BMI documentation, family counseling and goal setting for a healthy weight. Educates parents through newsletters, health education and providing incentives.

Contra Costa Health Plan – Developed an additional weight management program and expanded disease management program for obesity, nutrition and physical activity education.

HealthNet HMO – Restructured Fit Families for Life Be in Charge weight management program with coaching support, home-based family intervention and nutrition.

Health Plan of San Joaquin – Participates in the Central California Regional Obesity Prevention Program, aimed at creating healthier communities to support healthier eating and active living.

Health Plan of San Mateo – Implemented Shape Down – a weight management program, expanded to meet the needs of Spanish speakers.

Obesity

Inland Empire Health Plan – Implemented a program to increase the availability of diabetes and weight loss programs during off-hours or weekends.

L.A. Care – Expanded the childhood weight management/prevention program through the following: developed a “fotonovela” on childhood obesity for the Latino community; expanded health education resources to the high desert region using a mobile health education program to provide individualized nutrition therapy for subscribers with chronic disease through disease management. Health workshops were provided in centralized locations.

Molina Healthcare – Offered pediatric obesity management training to providers and staff on screening, counseling, follow-up and how to access in-house community resources.

Santa Clara Family Health Plan – Developed a new obesity program flyer for subscribers, offers nutrition and weight management classes in English, Spanish and Vietnamese.

Ventura County Health Care Plan – Created an obesity quality improvement program which includes weight loss, healthy eating and exercise.

Asthma/Upper Respiratory Infection

Introduction

All 22 HFP health plans identified asthma/upper respiratory infection as a major health condition with subscribers.

Asthma is a frequently diagnosed condition and the leading cause of pediatric hospitalizations for California children[8] and is a major contributing factor for children absent from school.[9] This suggests that plans/providers need to continue educating subscribers on self-management of asthma.

An upper respiratory infection (URI) is also known as the common cold. It is one of the most common illnesses, leading to more doctor visits and absences from school and work than any other illness every year. It is estimated that during a one-year period, people in the U.S. will suffer one billion colds.[10] A URI is caused by a virus and is not affected by antibiotics. A rapidly growing public health concern is that several strains of bacteria have become resistant to antibiotics due to overuse and improper use of antibiotics. This reduces the amount of effective antibiotics doctors may prescribe when they are most needed. Nearly 90 percent of HFP subscribers were appropriately treated for the common cold in 2010.[11]

Most children will develop at least six to 10 colds a year. This number increases for children who attend daycare. Colds may occur less frequently after the age of six.

Common childhood conditions affecting all age groups and ethnicities of HFP subscribers include bronchitis, pharyngitis, otitis media and allergic rhinitis.

Disparities

According to the UCLA Center for Health Policy Research report Income Disparities in Asthma Burden and Care in California, although asthma occurs among Californians at all socio-economic levels, it disproportionately affects people with low income. Californians who miss more days of work and school are more likely to have frequent asthma symptoms and go to the emergency department or be hospitalized for asthma care.[12]

- Children with asthma in low-income families miss 2.8 days of school on average compared to 1.3 days of school for children in higher-income families.
- Among families with incomes below 200 percent FPL, 23.9 percent of children went to an emergency department or urgent care facility in the past year because of asthma, compared with 12.5 percent of children in families with higher income.
- The hospitalization rate among children in low-income families was 5.8 percent compared to 1.1 percent of children in higher-income families.[13]

HFP health plans reported Hispanic subscribers have the greatest disparity for asthma, while the ethnic disparities

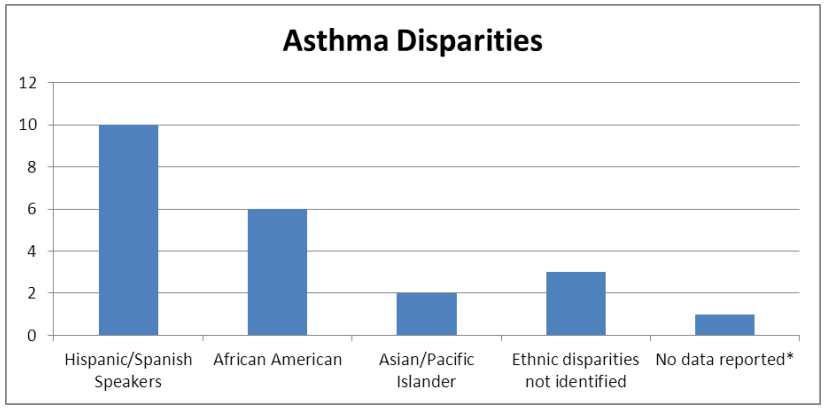
Asthma/Upper Respiratory Infection

for upper respiratory infections are highest in the Hispanic and African-American populations.

Chart 2 shows the highest number of ethnicities affected by asthma as reported by plans:

- A total of 10 plans reported Hispanic subscribers.
- Six plans reported African American subscribers.
- Two plans reported Asian/Pacific Islander subscribers.
- Three plans did not identify ethnic disparities among subscribers.
- One plan did not identify this condition.

Chart 2

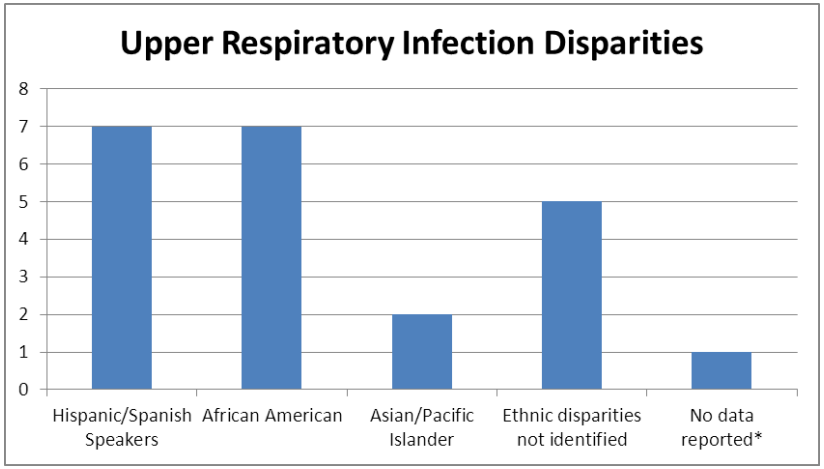


*Plan(s) did not provide data on this condition.

Chart 3 shows the highest number of ethnicities affected by upper respiratory infections as reported by plans:

- Seven plans reported Hispanic subscribers.
- Seven plans reported African American subscribers.
- Two plans reported Asian/Pacific Islander subscribers.
- Five plans did not identify ethnic disparities among subscribers.
- One plan did not identify this condition.

Chart 3



*Plan(s) did not provide data on this condition.

Asthma/Upper Respiratory Infection

Key Findings

According to 2010 HFP HEDIS findings, Korean-speaking families had the highest rate of subscribers receiving appropriate treatment for a URI among the primary language groups. Also, the rate of appropriate treatment for URI among African American subscribers was significantly higher than all other ethnic groups. HEDIS data also showed that nearly all subscribers or 94.5 percent in the Bay Area region received the appropriate treatment for an URI. Additionally, the youngest group (ages 12 to 24 months) had a significantly higher rate of appropriate treatment for URI than the other age groups.

Plan Projects

Anthem Blue Cross – Operates the Healthy Habits Count with Asthma program. This program focuses on working with asthma as well as managing and living with it.

Central California Alliance for Health – Promotes its Clinical Asthma Education benefit, which includes up to six hours of comprehensive self-management education provided or supervised by a respiratory therapist or asthma educator.

Community Health Group – Implemented a formalized asthma outreach program.

Contra Costa Health Plan – Developed materials for African Americans on asthma control and expanded its disease management program for asthma.

Health Plan of San Joaquin – Worked with the Central California Obesity Prevention Program to develop an active San Joaquin Asthma Coalition already in place in Stanislaus county; Asthma Disease Management which delivers incentives to providers and pharmacists for distributing health education materials to subscribers; School Asthma Flag Program was implemented in association with the American Lung Association and San Joaquin Valley Air Quality Control District. Schools raise a certain flag or color which identifies the air quality forecast of the day. The associated organizations recruited 13 schools to participate in the School Asthma Flag program. The Health Plan of San Joaquin is a major sponsor and participant in the Annual Asthma Summit which provides opportunities for researchers, healthcare providers, public health professionals, health educators, coalition members, asthma advocates and other interested individuals to hear about the latest in asthma research.

Asthma/Upper Respiratory Infection

L.A. Care Health Plan – Added a Pay for Participation program for subscribers to increase well-child visits from children 2-19 years; developed an asthma home visits program and increased asthma outreach at community health fairs; expanded health education resources to the high desert region using a mobile health education program focusing on asthma and chronic disease management and to provide additional health education materials on tobacco, gout and asthma; and provided health workshops in centralized locations.

Molina Healthcare – Identified community based programs that provide free asthma education and conduct home environmental assessments to identify asthma triggers.

Ventura County Health Care Plan – Implemented a full asthma disease management program.

Diabetes

Introduction

Diabetes is one of the most common chronic diseases in children and adolescents. More than 151,000 Americans below the age of 20 years have diabetes according to the Centers for Disease Control and Prevention (CDC).[14]

CDC information also reports that diabetes diagnosed during childhood is often assumed to be Type 1 (juvenile-onset diabetes). However, in the last two decades, Type 2 diabetes (formerly adult-onset diabetes) has been frequently reported among U.S. children and adolescents.

Children and adolescents diagnosed with Type 2 diabetes are generally between 10 and 19 years old, obese, have a strong family history of Type 2 diabetes and are insulin resistant.[15]

The number of people with diabetes in California is expected to double by the year 2020. About 18,000 (2.3 per 1,000) of the state's children between ages 5-19 were diagnosed with diabetes in 2008, 15,000 with Type 1 and 3,000 with Type 2. Recent studies have consistently shown a rise in Type 2 diabetes among children and youth.[16]

What is Diabetes?

Diabetes is a chronic disease in which blood glucose (sugar) levels are above normal. This medical condition results from defects in insulin production, insulin action or both.[17]

Managing diabetes is important to long-term health. Over the years, ongoing high blood glucose, also called hyperglycemia, can lead to serious health problems such as heart disease, blindness and kidney failure.[18]

Types of Diabetes

Type 1 diabetes, previously known as juvenile diabetes, is an autoimmune disease in which the body does not produce the hormone insulin. There is no way to prevent Type 1 diabetes.[19]

Type 2 diabetes, previously called non-insulin-dependent diabetes or adult-onset diabetes, accounts for 90-95 percent of all cases diagnosed in adults. It usually begins as insulin resistance, a disorder in which the cells do not use insulin properly. As the need for insulin rises, the pancreas gradually loses its ability to produce it. Studies have shown that lifestyle interventions to lose weight and increase physical activity can reduce the development of Type 2 diabetes by 58 percent for people at risk.[20]

According to Banner Health, a non-profit children's health care organization in Arizona, it is possible to detect a condition that is developing before a child or teenager develops Type 2 diabetes. This condition is known as pre-diabetes.[21]

With pre-diabetes, individuals have blood glucose or A1c levels higher than normal, but not high enough to be classified as diabetes. People with pre-diabetes have an increased risk of developing Type 2 diabetes, heart disease and stroke. Without intervention, about one in

Diabetes

four people with pre-diabetes will develop diabetes within three to five years.[22]

Diabetes is a chronic disease that can be controlled and complications delayed or avoided. Consistent self-management and access to quality diabetes care are essential. Many people first become aware that they have diabetes when they develop one of its life-threatening complications.[23] For that reason, diabetes screening in children and adolescents is critical for early detection and treatment.

Disparities

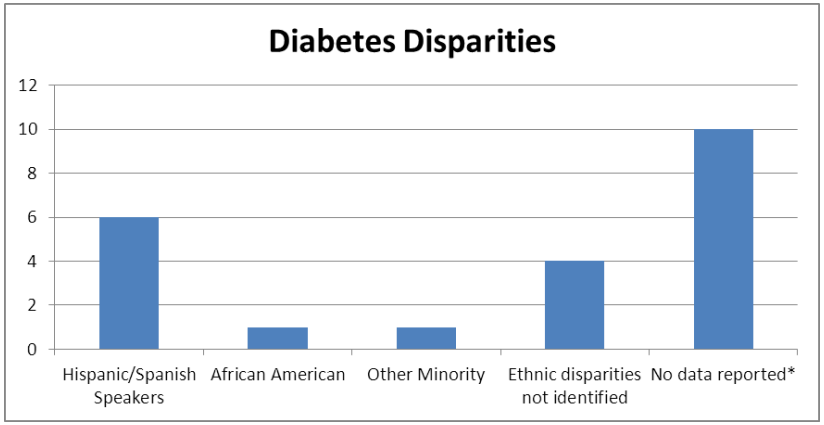
The National Institute of Diabetes and Digestive and Kidney Diseases reports that in 2010, 25.8 million people, or 8.3 percent of the population were diagnosed with diabetes, leaving nearly seven million undiagnosed. African Americans, Hispanic/Latino Americans, American Indians, some Asian Americans, Native Hawaiians and other Pacific Islanders are at particularly high risk for Type 2 diabetes and its complications.[24] In California, 3.9 million people or 13.8 percent of the population have diabetes. Among the states, California has the greatest number of new cases of diabetes annually. Cases of diabetes have increased 32 percent over the past decade and costs in California exceed $24 billion annually.[25]

HFP health plans reported that Hispanics have the greatest ethnic disparity in terms of treatment, while they compose the majority of subscribers in HFP. However, only six of 22 plans reported on this condition and 14 plans stated they were unable to report the data.

Chart 4 shows the highest number of ethnicities that are affected by diabetes as reported by health plans:

- Six plans reported Hispanic subscribers.
- One plan reported African American subscribers.
- One plan reported subscribers in the Other Minority group.
- Four plans did not identify ethnic disparities among subscribers.
- A total of 10 plans did not identify this condition.

Chart 4



*Plan(s) did not provide data on this condition.

Diabetes

Key Findings

According to the 2012 California Diabetes Program Fact Sheet, California Department of Public Health, University of California, San Francisco, ethnic minorities and those who are poor or disadvantaged have especially high rates of diabetes. In 2010, diagnosed diabetes prevalence was much higher among those with a family income below 100 percent FPL at 10.2 percent, compared to those whose income was above 300 percent FPL, at 6.7 percent. In 2008, one in six or 16.1 percent of adolescents ages 12-19 had pre-diabetes.[26]

Plan Projects

CenCal Health – Began educational mailings in July 2012 with diabetes information Diabetes SMART to subscribers newly diagnosed with diabetes.

Community Health Group – Instituted training on latest diabetes management strategies to providers and health educators.

Contra Costa Health Plan – Expanded a disease management program for asthma and the use of the HOPE Program, which targets 2-11 year olds with high BMI count and those subscribers with pre-diabetes and Type 2 diabetes.

L.A. Care Health Plan – Expanded health education resources to the high desert region using a mobile health education program focusing on diabetes and chronic disease management. Health workshops were provided in centralized locations.

San Francisco Health Plan – Added new health education information to the SFHP website. Diabetes materials were mailed to subscribers and outreach calls were made to subscribers enrolling in the six-week chronic disease management program.

Mental Health/Substance Abuse

Introduction

Adolescence is an important time to prevent, detect and treat mental health issues as many illnesses often appear for the first time during the teenage years. Research has shown that the symptoms of mental illness can be hard to recognize because it can be mistaken for normal cognitive, behavioral and emotional changes during adolescence. Among those changes, which can contribute to the expression of mental health conditions, are sleep disturbances, hormonal changes, substance use and increased levels of stress and academic pressures.[27]

According to the California Adolescent Health Collaborative, mental and emotional health disorders that go unrecognized or untreated increase the risk of school failure and dropout, alcohol and drug use, HIV transmission, somatic ailments and suicide in adolescents.[28]

Suicide rates increase dramatically as teens move from early adolescence to middle adolescence and to young adulthood. Research found that suicide was the second leading cause of death for adolescents aged 12-17 years, in 2010.[29]

Given the high level of depression among young people, it is critical to raise awareness on the signs of adolescent depression, to increase screening for adolescent depression in multiple health care settings, including primary care, and to more widely disseminate information on the availability of treatment options for adolescents.

Disparities

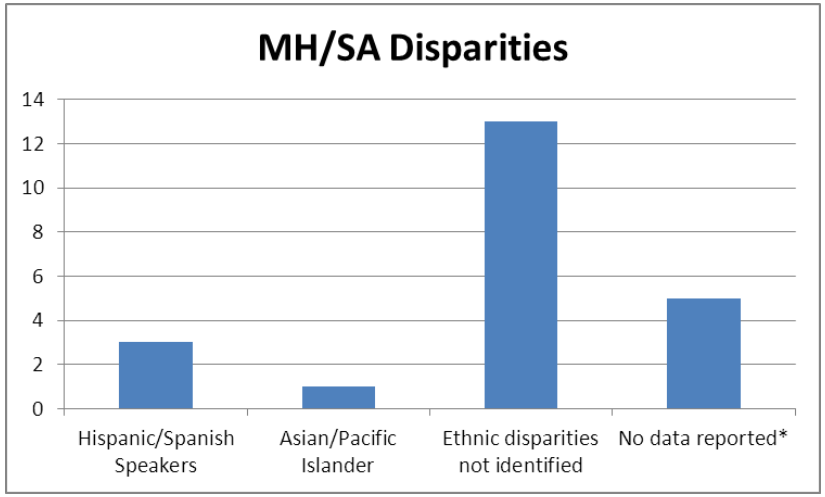
According to emotional health research from www.kidsdata.org, almost one-third of adolescents in California have reported depressed feelings. Between 2008 and 2010, 34 percent of Asian/Pacific Islander youth reported depressed feelings; 31.6 percent of Native American/Alaskans similarly reported, as did 31.4 percent of Hispanics; 28.8 percent of African-Americans; 27.8 percent of Asians; 27.2 percent of Whites and 30.1 percent comprising other ethnic groups.[30]

Seventeen HFP health plans identified mental health/substance abuse as another major health issue for HFP subscribers. Chart 5 on the next page identifies the highest number of ethnicities affected by mental health and substance abuse as reported by plans:

- Three plans reported Hispanic subscribers.
- One plan reported Asian subscribers.
- A total of 13 plans did not identify ethnic subscriber disparities.
- 5 plans did not identify this condition.

Mental Health/Substance Abuse

Chart 5



*Plan(s) did not provide data on this condition.

Key Findings

CenCal Health – More than half or 61 percent of adolescents in Santa Barbara report being substance free (not using alcohol, drugs or tobacco in the past 30 days) and this number is improving.

Community Health Plan – HFP subscribers identified with substance abuse issues decreased by 31.9 percent (from 69 to 47) since the 2007 GNA.

Health Plan of San Mateo – Ranked number one, at 28.7 percent, in the percentage of teens who indicated that their doctor talked to them regarding issues relating to depression, mental health and relationships.

Plan Projects

HFP health plans are contractually required to report on current and planned activities and to increase screening of young subscribers in the areas of behavioral health and developmental issues in subscribers under age five. Examples include:

Alameda Alliance for Health – Improved access for medical/mental health services through diverse outreach.

CalOptima – Conducted a behavioral health pilot program of telephonic behavioral health assessments and support services to help subscribers with behavioral health care needs.

Contra Costa Health Plan – Developed materials for parents of teens to reduce rates of alcohol and other drug usage, depression and suicide, as well as supported providers with educational resources on mental health.

Health Net – Continued providing the Quit for Life telephone-based program where subscribers are assessed and counseled via telephone by a trained tobacco cessation counselor.

Kern Health Systems – Expanded health education materials on mental health, including depression screening, eating disorders and behavioral problems including Attention Deficit Hyperactivity Disorder.

Results of the GNA Subscriber Survey-Language Access

As a part of the GNA process, plans were also required to conduct a subscriber survey to inform their analysis. MRMIB provided plans with a GNA survey consisting of 13 questions regarding the following subjects:

- Perceived health needs and expectations.
- Reported language needs.
- Preferred methods of learning.
- Availability and accessibility of health information.
- Lifestyle choices and behaviors which influence health (e.g. tobacco use).
- Access to language services.
- Access to health education services.
- Access to technology.
- Subscriber's perception of health care experiences.
- Subscriber's perception of whether cultural and linguistic health care services and/or education received from their provider met their needs.

A total of 19 plans out of 22 administered the survey. The purpose of the survey was to learn subscriber's opinions on how well the plans met their linguistic needs. MRMIB tabulated the responses for questions 1 through 4b. These questions were specifically related to language access issues. Questions 5 through 13, which were not tabulated for this report, addressed how subscribers prefer to receive health information. Additionally, responses to questions 5 through 13 were not included in this report because MRMIB allowed plans to modify these questions. Consequently, the survey responses were too inconsistent to tabulate. The following summary of responses to survey questions 1 through 4b attempts to identify language barriers experienced by HFP subscribers communicating with their doctors or obtaining interpreter servicers.

Results of the GNA Subscriber Survey-Language Access

Question 1. What language do you prefer to speak when talking with the primary care doctor?
Responses to the GNA Subscriber Survey indicated 50 percent of respondents preferred to speak with their health provider in Spanish, 40 percent in English, 3 percent in Cantonese, 2 percent in Vietnamese and 1 percent in Mandarin. Other languages represent 4 percent of the total responses. See Figure 1 and Table 1

Figure 1

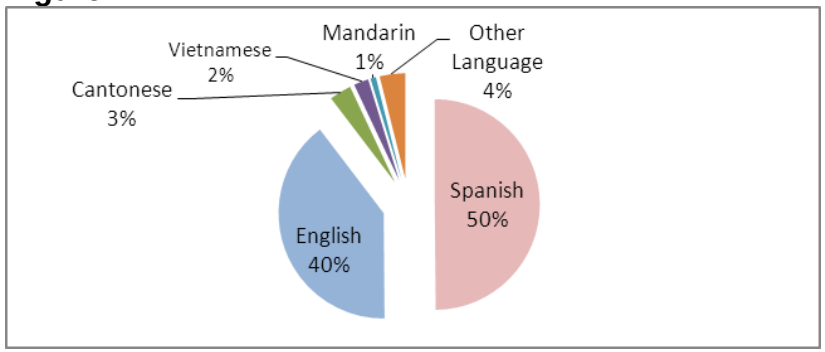


Table 1 – Responses by Language

Language	Health Plan Totals by Language	Total Responses % by Language
Spanish	5,243	49.86%
English	4,180	39.75%
Cantonese	355	3.38%
Vietnamese	237	2.25%
Mandarin	87	0.83%
Other Language	413	3.93%
Total Responses	**10,515**	**100%**

Question 2. Does the doctor speak your language?
A total of 78 percent of respondents indicated their doctor spoke their language. The remaining 22 percent indicated their doctor did not speak their language were comprised of 10 percent English speakers, almost 10 percent Spanish speakers and 1 percent Other. Chinese and Vietnamese speakers were less than 1 percent of the respondents. See Figure 2 and Table 2.

Figure 2

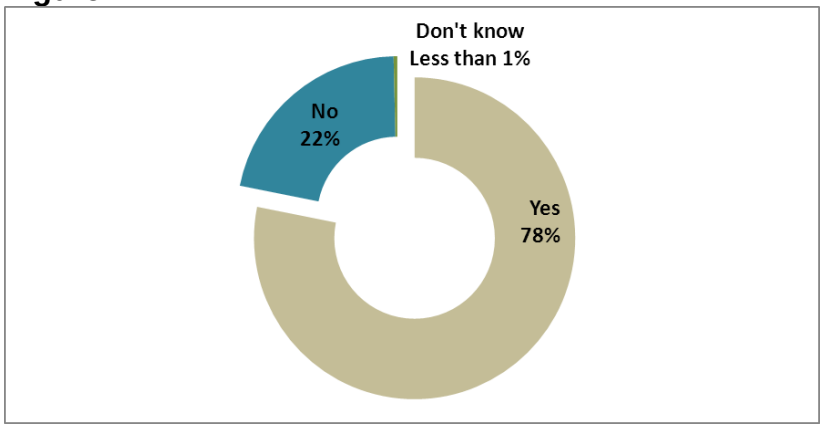


Table 2 – Responses by Language

Languages	Yes	No	Don't know	Total
English	48.3%	10.2%	0.3%	58.7%
Spanish	24.1%	9.4%	0.1%	33.6%
Vietnamese	2.5%	0.3%	0.0%	2.8%
Other	1.8%	1.0%	0.0%	2.8%
Chinese	1.5%	0.6%	0.0%	2.1%
Total Percentages	**78.1%**	**21.5%**	**0.4%**	**100%**

Question 3. How well do you speak English?
A total of 40 percent of respondents replied they speak English very well, 24 percent well, 25 percent not well and 11 percent not at all. See Figure 3 and Table 3.

Figure 3

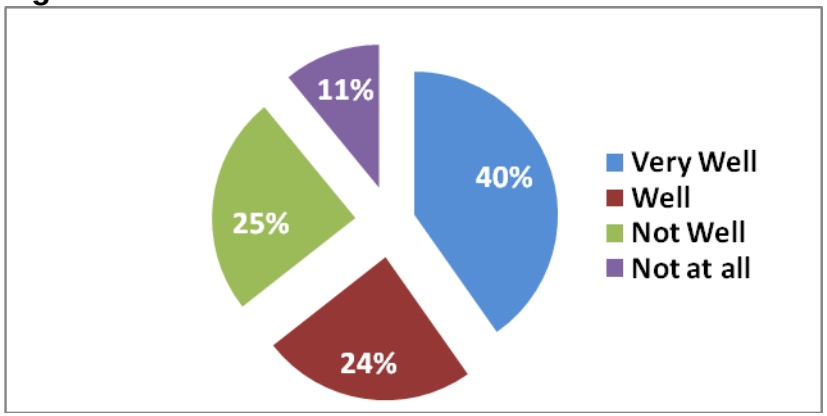


Table 3 – Responses by Language

Languages	Very Well	Well	Not Well	Not at all	Total
English	32.6%	9.9%	8.7%	4.0%	55.1%
Spanish	3.9%	7.5%	12.2%	6.4%	30.1%
Chinese	0.3%	2.5%	1.0%	0.2%	4.0%
Vietnamese	0.1%	0.6%	1.4%	0.1%	2.2%
Other*	3.4%	3.6%	1.4%	0.2%	8.6%
Total Percentages	**40.2%**	**24.2%**	**24.6%**	**11.0%**	**100%**

*One plan did not report responses by language for this question so their responses were recorded in the "Other" category.

Question 4a. Do you need an interpreter when talking with the doctor? An interpreter can explain what the doctor says in your language.
The majority of respondents or 71 percent, said they did not need an interpreter when talking with their doctor. Of the remaining 29 percent that did need an interpreter, 11 percent spoke English, 16 percent Spanish, 0.5 percent Chinese, 0.4 percent Vietnamese and 1 percent Other. See Figure 4 and Table 4.

Figure 4

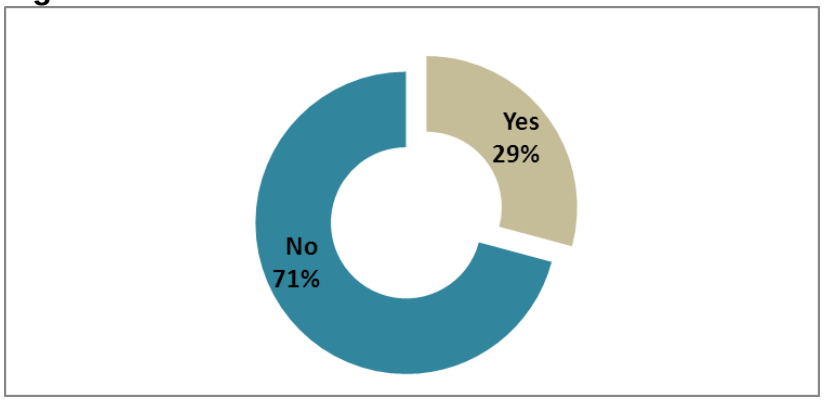


Table 4 – Responses by Language

Languages	Yes	No	Total
English	10.9%	47.8%	58.7%
Spanish	16.3%	16.1%	32.4%
Chinese	0.5%	1.2%	1.7%
Vietnamese	0.4%	1.7%	2.1%
Other*	1.0%	4.0%	5.0%
Total Percentages	**29.2%**	**70.8%**	**100%**

*One plan did not report responses by language for this question so their responses were recorded in the "Other" category.

Results of the GNA Subscriber Survey-Language Access

Question 4b. If Yes, who most often interprets for you?

A total of 85 percent of subscribers answering question 4b used an interpreter while talking with their doctor. The remaining 15 percent indicated no one interpreted for them while they talked with their doctor. The 15 percent consisted of 8.7 percent English speaking subscribers, 4.6 percent Spanish, 0.7 percent Chinese, 0.7 percent Vietnamese and 0.7 percent Other. See Figure 5 and Table 5.

Figure 5

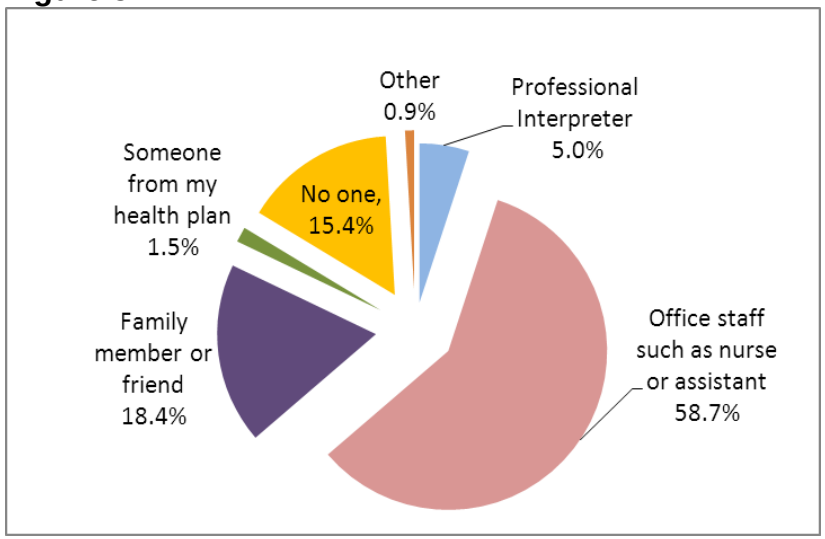


Table 5 – Responses by Language

Interpreter	English	Spanish	Vietnamese	Chinese	Other*	Total %
Office staff such as nurse or assistant	23.7%	32.5%	0.8%	0.7%	1.0%	**58.7%**
Family member or friend	8.6%	8.3%	0.3%	0.4%	0.8%	**18.4%**
No one	8.7%	4.6%	0.7%	0.7%	0.7%	**15.4%**
Professional Interpreter	1.5%	3.0%	0.2%	0.2%	0.2%	**5.0%**
Someone from my health plan	0.8%	0.5%	0.0%	0.1%	0.1%	**1.5%**
Other	0.4%	0.4%	0.0%	0.0%	0.0%	**0.9%**

*One plan did not report responses by language for this question so their responses were recorded in the "Other" category.

Cultural and Linguistics Services Survey Report

Since the program's inception in 1998, MRMIB has required all plans participating in HFP to report annually on the services they provide to meet the cultural and linguistic needs of their subscribers.

In April 2012, MRMIB issued the 2010 Cultural and Linguistic Services Survey Report for services provided during the period of July 1, 2009 through September 30, 2010. A total of 31 health, dental and vision plans contributed to the report. The report provided MRMIB an opportunity to evaluate plan methods to meet the needs of LEP subscribers. While most HFP plans are providing subscribers with interpreter and translation services, there were several challenges related to the plan's ability to track and report some data. For example, less than half of the plans were able to provide cost information for interpretation services because either the information was only tracked at the provider level and not reported to the plan or the plan did not specifically track the cost for HFP. This was also the first year that MRMIB asked the plans to report the number of requests for interpretation services by language and how the services were provided. Plan responses showed that in many cases, plans were unable to report this data specific to HFP.

The 2010 Cultural and Linguistic Report can be accessed at http://www.mrmib.ca.gov/MRMIB/Reports.html

Subsequent to the issuance of that report, HFP plans submitted reports for the 2010-11 benefit year. However, MRMIB found that plan submitted responses did not vary materially from the prior year, and determined not to prepare a separate report. Due to the transition of HFP subscribers to the Medi-Cal program in 2013, MRMIB did not require plans to submit reports covering the 2011-12 benefit year.

All plans reported that they ensure the proficiency of interpreters and translators using one or more of the following methods or certification:

- Certified translators and interpreters.
- Certificates of Attestation.
- Interpreter's reputation.
- Other methods of ensuring proficiency.

HFP contracts require documents sent to subscribers be at a 6th grade reading level. The majority of plans (27 of 31) use internal staff to verify a 6th grade reading level, as well as one or more of the following:

- SMOG Readability Formula.
- FRY Readability Formula.
- Flesch-Kincaid Tests.

Most plans reported using one or more methods to ensure the quality of interpretation services provided by third-party vendors, including:

- Requiring interpreters be certified.
- Relying on vendors to enforce quality provisions specifically related to interpretation services.
- Having contracts with third-party vendors that require them to follow the National Standards of Practice for Interpreters in Health Care.

- Requesting an explanation of methods used for quality assurance during the vendor solicitation process.
- Other quality assurance methods, which include monitoring and investigating grievances and complaints.

The HFP plans are also contractually required to provide information to subscribers on interpreter services. Overall most plans comply with the requirement.

The survey results and information obtained from the other quality monitoring activities indicate that overall the health plans are complying with the HFP cultural and linguistic requirements. However, there were several challenges in collecting accurate data on the number of subscribers that needed interpreter services and how these needs were met. Were it not for the transition of HFP, MRMIB would have continued to work with plans to improve the ability to track and report on how they were meeting the needs of their LEP subscribers. MRMIB would recommend that public programs that serve LEP individuals monitor the quality and effectiveness of services available and incorporate focus groups and targeted consumer surveys of LEP families.

Language and Access Requirements

The purpose of language access requirements are to ensure that subscribers and families in HFP with limited proficiency in English have meaningful access to all services provided. Language access requirements demonstrate a commitment to provide meaningful access to all individuals seeking benefits and services, including individuals with limited English proficiency. Parents of HFP subscribers should not face obstacles to getting and receiving child health care services for which they may be eligible because they do not speak, understand or read and write English.

In compliance with Title 6 of the Civil Rights Act, which prohibits discrimination against persons based on race, color or national origin, individuals with limited English proficiency are entitled to equal access through interpreter services. MRMIB has been committed to improving the cultural and linguistic competency of health providers and health systems to effectively serve California's diverse communities.

As part of this effort, language access provisions are incorporated into HFP contracts. These include:

Cultural and Linguistic Services

- HFP plans are to provide information to their network providers on the language needs of subscribers.

- The plans must provide 24-hour access to interpreter services for all LEP subscribers seeking health services from providers within the plan's network. Face-to-face interpreters are preferred, but if face-to-face interpreter services are not feasible, the plans may use telephone language lines for interpreter services.

- The plans must train staff on the policies and procedures, and monitoring of its language assistance program. Subcontracted providers must comply with these requirements also.

- When the need for an interpreter has been identified by a provider or requested by a subscriber, the plan will provide competent interpreters for scheduled appointments. The plan also ensures timely delivery of language assistance services for emergency, urgent and routine health care to persons of LEP. The plans are to instruct the providers within its network to record the language needs of subscribers in the medical record.

- The plans will use qualified interpreters and agrees that subscribers are not to be required or encouraged to use family members or friends as interpreters.

- The plans are to inform subscribers and its network providers of the availability of, and how to access linguistic services. Information provided to subscribers and providers regarding interpreter services includes but is not limited to:

  - The availability of interpreter services to subscribers at no charge.
  - The right not to use family members or friends as interpreters.
  - The right of a subscriber to request an interpreter during discussions of medical information, such as diagnoses of medical conditions and proposed treatment options, and explanations of plans of care or other discussions with providers.
  - The subscriber's right to file a complaint or grievance if linguistic needs are not met.

- The plans must ensure there is appropriate bilingual proficiency at medical and non-medical points of contact when providers list their bilingual capabilities in provider directories. Medical points of contact include advice and urgent care telephone lines and face-to-face encounters with providers who provide medical or health care advice to subscribers. In addition, non-medical points of contact include subscriber/customer service, plan or provider office reception, appointment services and subscriber orientation sessions.

- Plans also identify and report the on-site linguistic capability of providers and provider office staff through their Network Information Service report.

- If the plan fails to meet the Cultural and Linguistic requirements, the plan will be required to submit a corrective action plan that corrects the deficiency within a specified time period.

Translation of Written Materials

MRMIB plans are required to translate written information materials for subscribers including, but not limited to, the following:

  - Evidence of Coverage or Certificate of Insurance booklet.
  - Form letters, notice of action letters, consent forms and letters containing important information regarding participation in the health plan.
  - Notices pertaining to the reduction, denial, modification or termination of services; notices of the right to appeal such actions or that require a response from subscribers, grievance forms and notices pertaining to the right to seek Independent Medical Review.
  - Notices advising LEP subscribers of the availability of free language assistance services, other outreach materials and medical care reminders.
  - Written informing materials provided at a sixth-grade reading level or as determined appropriate through the plan's Cultural and Linguistic Needs Assessment.

- All subscriber materials are translated into Spanish and any other language representing either 5 percent or more of the plan's enrollment or

3,000 or more subscribers of the plan's enrollment in the program as of December 1 of the previous year. In addition, if the plan serves both HFP and Medi-Cal subscribers, the plan is encouraged to translate HFP subscriber materials into additional Medi-Cal threshold languages not required by HFP.

- The plans ensure the quality of translated materials. Plans are encouraged to use different qualified translators during sequential levels of the translation process to ensure accuracy, completeness and reliability of translated materials. The translation process includes the use of qualified translators for translating, editing, proofreading and professional review.

Collection and Use of Ethnicity and Primary Language Data

Consistent with federal regulations, the procedure for MRMIB obtaining and communicating data to the plans regarding race/ethnicity and language includes the following:

- Subscriber race/ethnicity and family primary language is collected at the time of application and eligibility determination. The information is entered into the eligibility system and transferred via the Electronic Data Interchange.
- HFP race/ethnicity categories include: White; Hispanic/Latino; African American; Asian / Pacific Islander; Alaskan Native or American Indian; Arabic; Armenian; Cambodian; Farsi; French; Hebrew; Hmong; Ilocano; Italian; Japanese; Lao; Portuguese; Samoan; Tagalog; Thai and Turkish.
- Data is transmitted daily to plans from the enrollment vendor via 834 transactions and with a monthly full file update.

MRMIB uses the race/ethnicity and family primary language data from the enrollment file to perform demographic analysis in a number of quality and utilization measurement reports, including the Dental Quality, HEDIS, CAHPS and Dental Consumer Assessment of Healthcare Providers and Systems reports.

Group Needs Assessment Report

HFP plans are contractually required to conduct a GNA to identify the health education, cultural and linguistic needs of HFP subscribers, describe available health education and cultural and linguistic (C&L) programs and resources, identify gaps in services and propose activities to address identified needs. The needs of subscribers, LEP subscribers, and subscribers from diverse cultural and ethnic backgrounds, must be specifically addressed in the GNA findings. Plans use the GNA findings to plan and implement culturally competent and linguistically appropriate services, health education and continuous quality improvement programs and services. Plans must use multiple reliable data sources, methodologies, techniques and tools to conduct the GNA.

The goal of the GNA is to improve the health outcomes of HFP subscribers by evaluating subscriber health risks, identifying health needs, prioritizing health education, C&L services and quality improvement programs and resources.

The HFP plans must submit the entire GNA Report every five years. In addition, the plans must prepare an annual work plan that incorporates and reflects findings from the GNA Report and annual GNA Updates. The work plan must include implementation activities, timelines with milestones, responsible individuals and identify the individual with overall responsibility for implementation of the work plan.

Methodology and Data Sources

A full GNA report was due from all HFP health, dental and vision plans in September of 2011 and an annual update was required in 2012.

Data Sources

Plans obtained data on racial and ethnic health disparities, disease prevalence, languages spoken and claims and utilization data to gather information on the most common diagnoses and medications most frequently dispensed for their HFP subscribers. Plans used subscriber satisfaction surveys to asses and evaluate subscribers' ability to access health care, as well as their satisfaction with the services received. Those data sources are included in the table below.

Data Source	Plans using this Data Source
GNA Reports	22
HEDIS	22
Healthy People 2020	21
Subscriber Encounter Data	21
GNA Telephone Surveys	20
Ask CHIS	19
2007-10 CAHPS Reports	18
2010 Census Data	17
Internet - www.kidsdata.org	12
CCS Reports	10
Mental Health Reports	10
2005-09 American Community Survey	7

Lessons Learned

With the transition of HFP subscribers to the Medi-Cal Program underway in 2013, this is the final report MRMIB will publish on the GNA and the C&L Survey.

Since the inception of HFP, MRMIB has recognized the importance of addressing the language and cultural needs of subscribers. MRMIB strategies and tools for addressing cultural and linguistic services were developed in conjunction with the Advisory Committee on Quality and the statutorily created HFP Advisory Panel. MRMIB recommends that policymakers and other state programs implement similar advisory groups of subject matter experts and subscriber families to assist in the development of quality improvement initiatives and outreach efforts. In addition, MRMIB strongly urges reporting on compliance with C&L requirements. Plans should be required to report GNA results and address subscriber needs with particular focus on the racial and ethnic disparities identified through the use of internal quality and encounter/claims data.

Although HFP Plans were provided a report template and required to follow a specified format for the GNA, plans had latitude in determining the sources of data used to identify needs, gaps in service or other issues. As a result, MRMIB found it challenging to identify the most frequently cited health risks and needs based upon ethnicity or language across HFP plans. For that reason, other state programs using similar assessment strategies should consider requiring the submission of standardized data related to ethnicity and language in order to facilitate such analysis.

From each year to the next, throughout the entire program life of HFP, the consistent theme from all plans has been a dedication to developing projects, programs and assistance to meet the cultural and linguistic needs of subscribers. MRMIB recognizes each and every plan's efforts to assist the diverse populations served in HFP. Regardless of the state program that serves these subscribers, policymakers, program administrators and plans must continue to focus on ensuring that families have access to services in a language that they understand and that is sensitive to their culture.

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